REQUEST FOR COMMUNITY HEALTH NURSING

Elkhart County Health Department
608 Oakland Avenue, Elkhart, IN 46516
Phone:(574)523-2127 Fax:(574)523-2145

Prenatal (EDC)_____ Mother/Infant Family Aware: Y N

Referred By:_____ Referral Agency:_____

Date:_____

Mother:_____ DOB:_____ S M W D Phone:_____
last first
Address:_____

Other Contact Person:_____ Phone:_____

Prenatal Care: Y N Gest. Age:_____ Grav.___ Para___ Delivery: Vag C-Sec

Prenatal/Pregnancy History if applicable:_____

Language Spoken:_____Race:_____

Child Name:_____ DOB:_____BW:_____Sex:_____
last first
Place of Birth:_____

Physician:_____Physician:_____
mother child

Discharge Date:_____Discharge Wt.:_____Head Circumference:_____ Length:_____

Newborn Screening: Y N Newborn Hearing: Y N Hep B: Y N

Breast/Formula:_____

Parent's Ability, Attitude, Interaction:_____

_____

High Risk Factors:_____

_____

Employed: Y N Insurance: Y N Welfare: Y N

Other Agencies and Referrals: WIC Healthy Families Other:_____